STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING _____ B. WING _____	C 03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	**5226 E 82ND ST INDIANAPOLIS, IN 46250**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00165874, IN00166413, IN00168279, IN00168913, IN00169102, and IN00169700. Complaint IN00165874- Unubstantiated due to lack of evidence. Complaint IN00166413- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00168279- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00168913- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00169102- Unubstantiated due to lack of evidence. Complaint IN00169700- Substantiated. No deficiencies related to the allegations are cited. Survey dates: March 11, 12, 13, 16, 17, and 18, 2015 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Survey team: Chuck Stevenson RN Census bed type: SNF/NF: 108 Total: 108 Census payor type:	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING _____ B. WING _____	C 03/18/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	**5226 E 82ND ST INDIANAPOLIS, IN 46250**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Medicare: 19 Medicaid: 71 Other: 18 Total: 108 Sample: 7 Kindred Transitional Care & Rehab - Allison Pointe was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00165874, IN00166413, IN00168279, IN00168913, IN00169102, and IN00169700. Quality Review 03/23/15 by Lisa McColly	F 000		